



House of Representatives

General Assembly

File No. 145

February Session, 2018

Substitute House Bill No. 5205

House of Representatives, April 3, 2018

The Committee on Insurance and Real Estate reported through REP. SCANLON of the 98th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE CONNECTICUT LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-859 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2018*):

3 To provide protection for [policyowners, insureds, beneficiaries,
4 annuitants, payees and assignees of life insurance policies, health
5 insurance policies, annuity contracts, and supplemental contracts]
6 persons covered under section 38a-860, as amended by this act, subject
7 to certain limitations, against failure in the performance of contractual
8 obligations under life, health and annuity policies, plans or contracts
9 specified in section 38a-860, as amended by this act, due to the
10 impairment of the insurer issuing such policies, plans or contracts, an
11 association of member insurers is created to enable the guaranty of
12 payment of benefits and of continuation of coverages. Members of the
13 association are subject to assessment to provide funds to carry out the

14 purpose of sections 38a-858 to 38a-875, inclusive, and the association is
15 authorized to assist the commissioner in the prescribed manner in the
16 detection and prevention of insurer impairments.

17 Sec. 2. Section 38a-860 of the general statutes is repealed and the
18 following is substituted in lieu thereof (*Effective July 1, 2018, and*
19 *applicable to impairments and insolvencies occurring on or after said date*):

20 (a) Sections 38a-858 to 38a-875, inclusive, shall provide coverage for
21 the policies and contracts specified in subsection (f) of this section: (1)
22 To any person, except for a nonresident certificate holder under a
23 group policy or contract, who is the beneficiary, assignee or payee,
24 including a health care provider rendering services covered under a
25 health insurance policy or certificate, of the person covered under
26 subdivision (2) of this subsection, regardless of where the person
27 resides, and (2) any person who is the owner of, or certificate holder or
28 enrollee under, such policy or contract, other than an unallocated
29 annuity contract or a structured settlement annuity, and in each case
30 who (A) is a resident, or (B) is not a resident, provided (i) the member
31 insurer that issued such policy or contract is domiciled in this state, (ii)
32 the state in which the person resides has an association similar to the
33 association created by this section and sections 38a-837, 38a-838, 38a-
34 845, 38a-853, 38a-859, as amended by this act, 38a-862, as amended by
35 this act, 38a-863, as amended by this act, 38a-865, as amended by this
36 act, and 38a-866, as amended by this act, and (iii) the person is not
37 eligible for coverage by an association in any other state because the
38 insurer was not licensed in the state in which the person resides at the
39 time specified in the state's guaranty association law.

40 (b) For unallocated annuity contracts specified in subsection (f) of
41 this section, subdivisions (1) and (2) of subsection (a) of this section
42 shall not apply, and except as provided in subsections (d) and (e) of
43 this section, sections 38a-858 to 38a-875, inclusive, shall apply to: (1)
44 Any person who is the owner of the unallocated annuity contract if the
45 contract is issued to, or in connection with, a specific benefit plan
46 whose plan sponsor has its principal place of business in this state; and

47 (2) any person who is the owner of an unallocated annuity contract
48 issued to, or in connection with, government lotteries if the owners are
49 residents.

50 (c) For structured settlement annuities specified in subsection (f) of
51 this section, subdivisions (1) and (2) of subsection (a) of this section
52 shall not apply, and except as provided in subsections (d) and (e) of
53 this section, sections 38a-858 to 38a-875, inclusive, shall apply to a
54 person who is a payee under a structured settlement annuity, or to a
55 person who is a beneficiary of a payee if the payee is deceased, if the
56 payee: (1) Is a resident, regardless of where the contract owner resides,
57 or (2) is not a resident, provided: (A) (i) The contract owner of the
58 structured settlement annuity is a resident, or (ii) the contract owner of
59 the structured settlement annuity is not a resident, but the insurer that
60 issued the structured settlement annuity is domiciled in this state, and
61 the state in which the contract owner resides has an association similar
62 to the association created by sections 38a-858 to 38a-875, inclusive; and
63 (B) neither the payee, beneficiary or contract owner is eligible for
64 coverage by the association of the state in which the payee, beneficiary
65 or contract owner resides.

66 (d) Sections 38a-858 to 38a-875, inclusive, shall not provide coverage
67 to: (1) A person who is a payee or beneficiary of a contract owner
68 resident of this state, if the payee or beneficiary is afforded any
69 coverage by the association of another state; [or] (2) a person covered
70 under subsection (b) of this section, if any coverage is provided by the
71 association of another state to the person; or (3) a person who acquires
72 rights to receive payments through a structured settlement factoring
73 transaction as defined in 26 USC 5891(c)(3)(A), regardless of whether
74 the transaction occurred before, on or after the date 26 USC 5891
75 (c)(3)(A) became effective.

76 (e) Sections 38a-858 to 38a-875, inclusive, shall provide coverage to a
77 person who is a resident and, in special circumstances, to a
78 nonresident. In order to avoid duplicate coverage, if a person who
79 would otherwise receive coverage under sections 38a-858 to 38a-875,

80 inclusive, is provided coverage under the laws of any other state, the
81 person shall not be provided coverage under sections 38a-858 to 38a-
82 875, inclusive. In determining the application of the provisions of this
83 subsection in situations where a person could be covered by the
84 association of more than one state, whether as an owner, payee,
85 enrollee, beneficiary or assignee, sections 38a-858 to 38a-875, inclusive,
86 shall be construed in conjunction with the laws of other states to result
87 in coverage by only one association.

88 (f) (1) Sections 38a-858 to 38a-875, inclusive, shall provide coverage
89 to the persons specified in subsections (a) to [(d)] (e), inclusive, of this
90 section for policies or contracts of direct, nongroup life insurance,
91 health insurance, or [annuity policies or contracts] annuities and
92 supplemental contracts to such policies or contracts, for certificates
93 under direct group policies and contracts, and for unallocated annuity
94 contracts issued by member insurers, except as limited by said
95 sections. Annuity contracts and certificates under group annuity
96 contracts include, but are not limited to, guaranteed investment
97 contracts, deposit administration contracts, unallocated funding
98 agreements, allocated funding agreements, structured settlement
99 annuities, annuities issued to or in connection with government
100 lotteries and any immediate or deferred annuity contracts.

101 (2) Sections 38a-858 to 38a-875, inclusive, shall not provide coverage
102 for: (A) Any portion of a policy or contract not guaranteed by the
103 insurer, or under which the risk is borne by the policy or contract
104 holder; (B) any policy or contract of reinsurance, unless assumption
105 certificates have been issued; (C) except as set forth in subdivision (3)
106 of this subsection, any portion of a policy or contract to the extent that
107 the rate of interest on which it is based or the interest rate, crediting
108 rate or similar factor determined by use of an index or other external
109 reference stated in the policy or contract employed in calculating
110 returns or changes in value (i) averaged over the period of four years
111 prior to the date on which the member insurer becomes an impaired or
112 insolvent insurer under sections 38a-858 to 38a-875, inclusive, exceeds
113 the rate of interest determined by subtracting two percentage points

114 from Moody's corporate bond yield average averaged for that same
115 four-year period or for such lesser period if the policy or contract was
116 issued less than four years before the member insurer becomes an
117 impaired or insolvent insurer under sections 38a-858 to 38a-875,
118 inclusive, whichever is earlier, and (ii) on and after the date on which
119 the member insurer becomes an impaired or insolvent insurer under
120 sections 38a-858 to 38a-875, inclusive, whichever is earlier, exceeds the
121 rate of interest determined by subtracting three percentage points from
122 Moody's corporate bond yield average as most recently available; (D) a
123 portion of a policy or contract issued to any plan or program of an
124 employer, association or similar entity to provide life, health or
125 annuity benefits to its employees or members to the extent that such
126 plan or program is self-funded or uninsured, including, but not limited
127 to, benefits payable by an employer, association or similar entity under
128 (i) a multiple employer welfare arrangement as defined in Section 514
129 of the federal Employee Retirement Income Security Act of 1974, as
130 amended from time to time, (ii) a minimum premium group insurance
131 plan, or (iii) an administrative services only contract; (E) any stop-loss
132 or excess loss insurance policy or contract providing for the
133 indemnification of or payment to a policy owner, a contract owner, a
134 plan or another person obligated to pay life, health or annuity benefits;
135 (F) any portion of a policy or contract to the extent that it provides
136 dividends, experience rating credits, voting rights or provides that any
137 fees or allowances be paid to any person, including, but not limited to,
138 the policy or contract holder, in connection with the service to or
139 administration of such policy or contract; (G) any policy or contract
140 issued in this state by a member insurer at a time when it was not
141 licensed or did not have a certificate of authority to issue such policy
142 or contract in this state; (H) any unallocated annuity contract issued to
143 an employee benefit plan protected under the federal Pension Benefit
144 Guaranty Corporation, regardless of whether the federal Pension
145 Benefit Guaranty Corporation has yet become liable to make any
146 payments with respect to the benefit plan; (I) any portion of an
147 unallocated annuity contract that is not issued to, or in connection with
148 a specific employee, union or association of natural persons benefit

149 plan or a government lottery; (J) [any subscriber contract issued by a
150 health care center] a portion of a policy or contract to the extent that
151 the assessments required by section 38a-866, as amended by this act,
152 with respect to the policy or contract are preempted by federal or state
153 law; (K) a contractual agreement that establishes the insurer's
154 obligation by reference to a portfolio of assets that is not owned or
155 possessed by the insurance company; (L) an obligation that does not
156 arise under the express written terms of the policy or contract issued
157 by the member insurer to the enrollee, certificate holder, contract
158 owner or policy owner, including, but not limited to, (i) a claim based
159 on marketing materials, (ii) a claim based on side letters, riders or
160 other documents that were issued by the member insurer without
161 meeting applicable policy contract form filing or approval
162 requirements, (iii) a misrepresentation of or regarding policy or
163 contract benefits, (iv) an extra-contractual claim, or (v) a claim for
164 penalties or consequential or incidental damages; (M) a contractual
165 agreement that establishes the member insurer's obligations to provide
166 a book value accounting guaranty for defined contribution benefit plan
167 participants by reference to a portfolio of assets that is owned by the
168 benefit plan or its trustee, which in each case is not an affiliate of the
169 member insurer; (N) a portion of a policy or contract to the extent it
170 provides for interest or other changes in value to be determined by the
171 use of an index or other external reference stated in the policy or
172 contract, but that have not been credited to the policy or contract, or as
173 to which the policy or contract owner's rights are subject to forfeiture,
174 as of the date the member insurer becomes an impaired or insolvent
175 insurer under sections 38a-858 to 38a-875, inclusive, whichever is
176 earlier. If a policy's or contract's interest or changes in value are
177 credited less frequently than annually, then for purposes of
178 determining the values that have been credited and are not subject to
179 forfeiture under this subparagraph, the interest or change in value
180 determined by using the procedures defined in the policy or contract
181 shall be credited as if the contractual date of crediting interest or
182 changing values was the date of impairment or insolvency, whichever
183 is earlier, and shall not be subject to forfeiture; [and] (O) structured

184 settlement annuity benefits to which a payee or beneficiary has
185 transferred the payee's or beneficiary's rights in a structured settlement
186 factoring transaction as defined in 26 USC 5891(c)(3)(A), regardless of
187 whether the transaction occurred before or after said section became
188 effective; and (P) any policy or contract providing hospital, medical,
189 prescription drugs or other health care benefits pursuant to Part C, 42
190 USC 1395w21 et seq., [or] Part D, 42 USC 1395w101 et seq., or 42 USC
191 Chapter 7, Subchapter XIX, as [both] said parts and subchapter may be
192 amended from time to time, or any regulations issued thereunder.

193 (3) Subparagraph (C) of subdivision (2) of this subsection shall not
194 apply to any portion of a policy or contract, including any rider to such
195 policy or contract, that provides long-term care benefits or any other
196 health insurance benefits.

197 (g) The benefits for which the association may become liable shall in
198 no event exceed the lesser of: (1) The contractual obligations for which
199 the insurer is liable or would have been liable if it were not an
200 impaired insurer, or (2) (A) with respect to any one life, regardless of
201 the number of policies or contracts: (i) Five hundred thousand dollars
202 in life insurance death benefits, but no more than five hundred
203 thousand dollars in net cash surrender and net cash withdrawal values
204 for life insurance; (ii) five hundred thousand dollars in health
205 insurance benefits, including, but not limited to, any net cash
206 surrender and net cash withdrawal values; (iii) five hundred thousand
207 dollars in the present value of annuity benefits, including, but not
208 limited to, net cash surrender and net cash withdrawal values; (B) with
209 respect to each individual participating in a governmental retirement
210 plan established under Section 401, 403(b) or 457 of the United States
211 Internal Revenue Code of 1986, or any subsequent internal revenue
212 code of the United States, as amended from time to time, covered by
213 an unallocated annuity contract or the beneficiaries of each such
214 individual if deceased, in the aggregate, five hundred thousand dollars
215 in present value annuity benefits, including, but not limited to, net
216 cash surrender and net cash withdrawal values; (C) with respect to
217 each payee of a structured settlement annuity, or beneficiary or

218 beneficiaries of the payee if deceased, five hundred thousand dollars in
219 present value annuity benefits, in the aggregate, including, but not
220 limited to, net cash surrender and net cash withdrawal values, if any,
221 provided in no event shall the association be liable to expend (i) more
222 than the five hundred thousand dollars in the aggregate with respect
223 to any one individual under subparagraphs (A), (B) and (C) of this
224 subdivision, and (ii) with respect to one owner of multiple nongroup
225 policies of life insurance, whether the policy or contract owner is an
226 individual, firm, corporation or other person, and whether the persons
227 insured are officers, managers, employees or other persons, more than
228 five million dollars in benefits, regardless of the number of policies and
229 contracts held by the owner; (D) with respect to either (i) one contract
230 owner provided coverage under subdivision (2) of subsection (b) of
231 this section, or (ii) one plan sponsor whose plans own directly or in
232 trust one or more unallocated annuity contracts not included in
233 subparagraph (B) of subdivision (2) of this subsection, five million
234 dollars in benefits regardless of the number of contracts with respect to
235 the contract owner or plan sponsor, except that in the case where one
236 or more unallocated annuity contracts are covered contracts under
237 sections 38a-858 to 38a-875, inclusive, and are owned by a trust or
238 other entity for the benefit of two or more plan sponsors, coverage
239 shall be afforded by the association if the largest interest in the trust or
240 entity owning the contract or contracts is held by a plan sponsor whose
241 principal place of business is in this state and in no event shall the
242 association be obligated to cover more than five million dollars in
243 benefits with respect to all such unallocated contracts; [.]

244 [(h) The] and (E) the limits set forth in [subsection (g) of this section]
245 this subsection are limits on the benefits for which the association is
246 obligated before taking into account either the association's
247 subrogation and assignment rights or the extent to which those
248 benefits could be provided out of the assets of the impaired or
249 insolvent insurer that are attributable to covered policies. The costs of
250 the association's obligations under sections 38a-858 to 38a-875,
251 inclusive, may be met by the use of assets attributable to covered
252 policies or reimbursed to the association pursuant to the association's

253 subrogation and assignment rights.

254 (h) For purposes of sections 38a-858 to 38a-875, inclusive, benefits
255 provided by a long-term care rider to a life insurance policy or annuity
256 contract shall be considered the same type of benefits as the benefits
257 provided under the base life insurance policy or annuity contract to
258 which such rider relates.

259 (i) In performing its obligation to provide coverage under section
260 38a-865, as amended by this act, the association shall not be required to
261 guarantee, assume, reinsure, reissue or perform, or cause to be
262 guaranteed, assumed, reinsured, reissued or performed, the
263 contractual obligations of the insolvent or impaired insurer under a
264 covered policy or contract that does not materially affect the economic
265 value or economic benefit of the covered policy or contract.

266 Sec. 3. Section 38a-862 of the 2018 supplement to the general statutes
267 is repealed and the following is substituted in lieu thereof (*Effective July*
268 *1, 2018*):

269 As used in sections 38a-858 to 38a-875, inclusive:

270 (1) "Account" means either of the two accounts created under
271 section 38a-863, as amended by this act;

272 (2) "Association" means the Connecticut Life and Health Insurance
273 Guaranty Association created under section 38a-863, as amended by
274 this act;

275 (3) "Authorized assessment" or "authorized", when used in the
276 context of assessments, means a resolution that has been passed by the
277 board of directors of the association whereby an assessment will be
278 called immediately or in the future from member insurers for a
279 specified amount. An assessment is authorized when the resolution is
280 passed;

281 (4) "Benefit plan" means a specific employee, union or association of
282 natural persons benefit plan;

283 (5) "Called assessment" or "called", when used in the context of
284 assessments, means that a notice has been issued by the association to
285 member insurers requiring that an authorized assessment be paid
286 within the time frame set forth in the notice. An authorized assessment
287 becomes a called assessment when notice is mailed by the association
288 to member insurers;

289 (6) "Commissioner" means the Insurance Commissioner of this state;

290 (7) "Contractual obligation" means any obligation under a policy or
291 contract or certificate under a group policy or contract, or portion
292 thereof for which coverage is provided under section 38a-860, as
293 amended by this act;

294 (8) ["Covered policy"] "Covered contract" or "covered policy" means
295 any policy or contract within the scope of section 38a-860, as amended
296 by this act;

297 (9) "Entity" means a person other than a natural person;

298 (10) "Health insurance" means a policy or contract of health
299 insurance, including, but not limited to, a health care center subscriber
300 contract or certificate;

301 [(10)] (11) "Impaired insurer" means a member insurer that, after
302 October 1, 1972, is not an insolvent insurer, and is placed under an
303 order of rehabilitation or conservation by a court of competent
304 jurisdiction;

305 [(11)] (12) "Insolvent insurer" means a member insurer that after
306 October 1, 1972, is placed under an order of liquidation by a court of
307 competent jurisdiction with a finding of insolvency;

308 [(12)] (13) "Member insurer" means any insurer or health care center
309 licensed or [who holds] holding a certificate of authority to issue in this
310 state any kind of insurance or conduct any health care center business
311 to which sections 38a-858 to 38a-875, inclusive, apply under section
312 38a-860, as amended by this act, and may include an insurer or health

313 care center whose license in this state has been suspended, revoked or
314 voluntarily withdrawn; [. "Member insurer" does not include a health
315 care center;]

316 [(13)] (14) "Moody's corporate bond yield average" means the
317 monthly average corporates as published by Moody's Investors
318 Service, Inc., or any successor thereto;

319 [(14)] (15) "Owner", "policy holder", "policy owner" or "contract
320 owner" means the person who is identified as the legal owner under
321 the terms of the policy or contract or who is otherwise vested with
322 legal title to the policy or contract through a valid assignment
323 completed in accordance with the terms of the policy or contract and
324 properly recorded as the owner on the books of the member insurer.
325 "Owner", "policy holder", "policy owner" and "contract owner" [and
326 "policy owner"] does not include a person with a mere beneficial
327 interest in a policy or contract;

328 [(15)] (16) "Plan sponsor" means: (A) The employer in the case of a
329 benefit plan established or maintained by a single employer; (B) the
330 employee organization in the case of a benefit plan established or
331 maintained by an employee organization; or (C) in the case of a benefit
332 plan established or maintained by two or more employers or jointly by
333 one or more employers and one or more employee organizations, the
334 association, committee, joint board of trustees or other similar group of
335 representatives of the parties who establish or maintain the benefit
336 plan;

337 [(16)] (17) "Premiums" means amounts or considerations, by
338 whatever name called, received on covered policies or contracts less
339 premiums, considerations and deposits returned thereon, and less
340 dividends and experience credits thereon. "Premiums" does not
341 include (A) any amounts or considerations received for any policies or
342 contracts or for the portions of any policies or contracts for which
343 coverage is not provided under subsection (f) of section 38a-860, as
344 amended by this act, except that (i) assessable premium shall not be
345 reduced on account of subparagraph (C) of subdivision (2) of

346 subsection (f) of section 38a-860, as amended by this act, relating to
347 interest limitations, and subdivision (2) of subsection (g) of section 38a-
348 860, as amended by this act, relating to limitations with respect to any
349 one individual, any one participant and any one policy or contract
350 owner, [; provided further,] and (ii) "premiums" does not include any
351 premiums in excess of five million dollars on any unallocated annuity
352 contract not issued under a governmental retirement benefit plan
353 established under Section 401, 403(b) or 457 of the Internal Revenue
354 Code of 1986, or any subsequent corresponding internal revenue code
355 of the United States, as from time to time amended, or (B) with respect
356 to multiple nongroup policies of life insurance owned by one owner,
357 whether the policy owner or contract owner is an individual, firm,
358 corporation or other person, and whether the persons insured are
359 officers, managers, employees or other persons, premiums in excess of
360 five million dollars with respect to such policies or contracts,
361 regardless of the number of policies or contracts held by the owner;

362 [(17)] (18) "Person" means any individual, corporation, limited
363 liability company, partnership, association, governmental body or
364 entity, or voluntary organization;

365 [(18)] (19) "Principal place of business" of a plan sponsor or an entity
366 means the single state in which the natural persons who establish
367 policy for the direction, control and coordination of the operations of
368 the plan sponsor or entity as a whole primarily exercise that function,
369 as determined by the association in its reasonable judgment by
370 considering the factors set forth in subparagraphs (A) to (G), inclusive,
371 of this subdivision: (A) The state in which the primary executive and
372 administrative headquarters of the plan sponsor or entity is located;
373 (B) the state in which the principal office of the chief executive officer
374 of the plan sponsor or entity is located; (C) the state in which the board
375 of directors, or similar governing person or persons, of the plan
376 sponsor or entity conducts the majority of its meetings; (D) the state in
377 which the executive or management committee of the board of
378 directors, or similar governing person or persons, of the plan sponsor
379 or entity conducts the majority of its meetings; (E) the state from which

380 the management of the overall operations of the plan sponsor or entity
381 is directed; (F) in the case of a benefit plan sponsored by affiliated
382 companies comprising a consolidated corporation, the state in which
383 the holding company or controlling affiliate has its principal place of
384 business as determined using the factors set forth in subparagraphs
385 (A) to (E), inclusive, of this subdivision; and (G) notwithstanding
386 subparagraphs (A) to (F), inclusive, of this subdivision, in the case of a
387 plan sponsor, if more than fifty per cent of the participants in the
388 benefit plan are employed in a single state, that state shall be deemed
389 to be the principal place of business of the plan sponsor. The principal
390 place of business of a plan sponsor of a benefit plan described in
391 subparagraph (C) of [subdivision (15)] subdivision (16) of this section
392 shall be deemed to be the principal place of business of the association,
393 committee, joint board of trustees or other similar group of
394 representatives of the parties who establish or maintain the benefit
395 plan that, in lieu of a specific or clear designation of a principal place of
396 business, shall be deemed to be the principal place of business of the
397 employer or employee organization that has the largest investment in
398 the benefit plan in question;

399 [(19)] (20) "Receivership court" means the court in the insolvent or
400 impaired insurer's state having jurisdiction over the conservation,
401 rehabilitation or liquidation of the member insurer;

402 [(20)] (21) "Resident" means a person to whom a contractual
403 obligation is owed and who resides in this state on the date of entry of
404 a court order that determines a member insurer to be an impaired
405 insurer or a court order that determines a member insurer to be an
406 insolvent insurer, whichever occurs first. A person may be a resident
407 of only one state, which in the case of an entity shall be its principal
408 place of business. Citizens of the United States that are either (A)
409 residents of foreign countries, or (B) residents of United States
410 possessions, territories or protectorates that do not have an association
411 similar to the association created by sections 38a-858 to 38a-875,
412 inclusive, shall be deemed residents of the state of domicile of the
413 member insurer that issued the policies or contracts;

414 [(21)] (22) "Structured settlement annuity" means an annuity
415 purchased to fund periodic payments for a plaintiff or other claimant
416 in payment for or with respect to personal injury suffered by the
417 plaintiff or other claimant;

418 [(22)] (23) "Supplemental contract" means any agreement entered
419 into for the distribution of policy or contract proceeds under a life,
420 health or annuity policy or contract; and

421 [(23)] (24) "Unallocated annuity contract" means any annuity
422 contract or group annuity certificate that is not issued to and owned by
423 an individual, except to the extent of any annuity benefits guaranteed
424 to an individual by an insurer under such contract or certificate.

425 Sec. 4. Subsection (a) of section 38a-863 of the general statutes is
426 repealed and the following is substituted in lieu thereof (*Effective July*
427 *1, 2018*):

428 (a) There is created a nonprofit legal entity to be known as the
429 Connecticut Life and Health Insurance Guaranty Association. All
430 member insurers shall be and remain members of the association as a
431 condition of their authority to transact insurance or conduct health
432 care center business in this state. The association shall perform its
433 functions under the plan of operation established and approved under
434 section 38a-867 and shall exercise its powers through a board of
435 directors established under section 38a-864, as amended by this act.
436 For purposes of administration and assessment, the association shall
437 maintain two accounts:

438 (1) The life insurance and annuity account which includes the
439 following subaccounts:

440 (A) Life insurance account;

441 (B) [annuity] Annuity account which shall include, but is not limited
442 to, annuity contracts owned by a governmental retirement plan, or its
443 trustee, established under Section 401, 403(b) or 457 of the Internal
444 Revenue Code of 1986, or any subsequent corresponding internal

445 revenue code of the United States, as from time to time amended, but
446 shall otherwise exclude unallocated annuities; and

447 (C) [unallocated] Unallocated annuity account which shall exclude
448 contracts owned by a governmental retirement benefit plan, or its
449 trustee, established under Section 401, 403(b) or 457 of the Internal
450 Revenue Code of 1986, or any subsequent corresponding internal
451 revenue code of the United States, as from time to time amended; and

452 (2) [the] The health [insurance] account.

453 Sec. 5. Subsection (a) of section 38a-864 of the general statutes is
454 repealed and the following is substituted in lieu thereof (*Effective July*
455 *1, 2018*):

456 (a) The board of directors of the association shall consist of not less
457 than [five] seven nor more than [nine] eleven members serving terms
458 as established in the plan of operation. The members of the board shall
459 be selected by member insurers subject to the approval of the
460 commissioner. Vacancies on the board shall be filled for the remaining
461 period of the term in the manner described in the plan of operation. To
462 select the initial board of directors, and initially organize the
463 association, the commissioner shall give notice to all member insurers
464 of the time and place of the organizational meeting. In determining
465 voting rights at the organizational meeting each member insurer shall
466 be entitled to one vote in person or by proxy. If the board of directors
467 is not selected within sixty days after notice of the organizational
468 meeting, the commissioner may appoint the initial members.

469 Sec. 6. Section 38a-865 of the general statutes is repealed and the
470 following is substituted in lieu thereof (*Effective July 1, 2018, and*
471 *applicable to impairments and insolvencies occurring on or after said date*):

472 (a) If a member insurer is an impaired insurer, the association may,
473 in its discretion, and subject to any conditions imposed by the
474 association that do not impair the contractual obligations of the
475 impaired insurer and that are approved by the commissioner; [.]

476 (1) [guarantee] Guarantee, assume, reissue or reinsure, or cause to
477 be guaranteed, assumed, reissued or reinsured, any or all of the
478 policies or contracts of the impaired insurer; or

479 (2) [provide] Provide such moneys, pledges, loans, notes,
480 guarantees or other means as are proper to effectuate subdivision (1) of
481 this subsection and assure payment of the contractual obligations of
482 the impaired insurer pending action under subdivision (1) of this
483 subsection.

484 (b) If a member insurer is an insolvent insurer, the association shall,
485 in its discretion, either:

486 (1) (A) (i) Guarantee, assume, reissue or reinsure, or cause to be
487 guaranteed, assumed, reissued or reinsured, the policies or contracts of
488 the insolvent insurer, or (ii) assure payment of the contractual
489 obligations of the insolvent insurer, and (B) provide moneys, pledges,
490 loans, notes, guarantees or other means reasonably necessary to
491 discharge the association's duties; or

492 (2) Provide benefits and coverages in accordance with the following
493 provisions:

494 (A) With respect to [life and health insurance policies and annuities]
495 policies and contracts, assure payment of benefits [for premiums
496 identical to the premiums and benefits, except for terms of conversion
497 and renewability] that would have been payable under the policies or
498 contracts of the insolvent insurer, for claims incurred: (i) With respect
499 to group policies and contracts, not later than the earlier of the next
500 renewal date under those policies or contracts or forty-five days, but in
501 no event less than thirty days after the date on which the association
502 becomes obligated with respect to the policies and contracts; (ii) with
503 respect to nongroup policies, contracts and annuities, not later than the
504 earlier of the next renewal date, if any, under the policies or contracts
505 or one year, but in no event less than thirty days from the date on
506 which the association becomes obligated with respect to the policies or
507 contracts;

508 (B) Make diligent efforts to provide all known insureds, enrollees or
509 annuitants, for nongroup policies and contracts, or group policy or
510 contract owners with respect to group policies and contracts, thirty
511 days' notice of the termination of benefits pursuant to subparagraph
512 (A) of this subdivision;

513 (C) With respect to nongroup [life and health insurance policies and
514 annuities] policies and contracts covered by the association, make
515 available to each known insured or annuitant, or owner if other than
516 the insured, enrollee or annuitant, and with respect to an individual
517 formerly an insured, enrollee or [formerly an] annuitant under a group
518 policy or contract who is not eligible for replacement group coverage,
519 make available substitute coverage on an individual basis in
520 accordance with the provisions of subparagraph (D) of this
521 subdivision, if the insureds, enrollees or annuitants had a right under
522 law or the terminated policy, contract or annuity to convert coverage
523 to individual coverage or to continue an individual policy, contract or
524 annuity in force until a specified age or for a specified time during
525 which the insurer or health care center had no right to make unilateral
526 changes in any provision of the policy, contract or annuity or had a
527 right only to make changes in premium by class;

528 (D) In providing the substitute coverage required under
529 subparagraph (C) of this subdivision, the association may offer either
530 to reissue the terminated coverage or to issue an alternative policy or
531 contract at actuarially justified rates. Alternative or reissued policies
532 shall be offered without requiring evidence of insurability, and shall
533 not provide for any waiting period or exclusion that would not have
534 applied under the terminated policy or contract. The association may
535 reinsure any alternative or reissued policy or contract;

536 (E) Alternative policies or contracts adopted by the association shall
537 be subject to the approval of the [domiciliary insurance] commissioner,
538 [and the receivership court.] The association may adopt alternative
539 policies or contracts of various types for future issuance without
540 regard to any particular impairment or insolvency;

541 (F) Alternative policies or contracts adopted by the association shall
542 contain at least the minimum statutory provisions required in this state
543 and provide benefits that [shall not be] are not unreasonable in relation
544 to the premium charged. The association shall set the premium in
545 accordance with a table of rates that it shall adopt. The premium shall
546 reflect the amount of insurance to be provided and the age and class of
547 risk of each insured, but shall not reflect any changes in the health of
548 the insured after the original policy or contract was last underwritten;

549 (G) Any alternative policy or contract issued by the association shall
550 provide coverage of a type similar to that of the policy or contract
551 issued by the impaired or insolvent insurer as determined by the
552 association;

553 (H) If the association elects to reissue terminated coverage at a
554 premium rate different from that charged under the terminated policy
555 or contract, the premium shall be actuarially justified and set by the
556 association in accordance with the amount of insurance or coverage
557 provided and the age and class of risk, subject to prior approval of the
558 [domiciliary insurance] commissioner; [and the receivership court;]

559 (I) The association's obligations with respect to coverage under any
560 policy or contract of the impaired or insolvent insurer or under any
561 reissued or alternative policy or contract shall cease on the date the
562 coverage or policy or contract is replaced by another similar policy or
563 contract by the owner, the insured, the enrollee or the association;

564 (J) When proceeding under this subdivision with respect to a policy
565 or contract carrying guaranteed minimum interest rates, the
566 association shall assure the payment or crediting of a rate of interest
567 consistent with subparagraph (C) of subdivision (2) of subsection (f) of
568 section 38a-860, as amended by this act.

569 (c) Nonpayment of premiums by the thirty-first day after the date
570 required under the terms of any guaranteed, assumed, alternative or
571 reissued policy or contract or substitute coverage shall terminate the
572 association's obligations under the policy, contract or coverage under

573 sections 38a-858 to 38a-875, inclusive, with respect to the policy,
574 contract or coverage, except with respect to any claims incurred or any
575 net surrender value that may be due in accordance with the provisions
576 of sections 38a-858 to 38a-875, inclusive.

577 (d) Premiums due for coverage after entry of an order of liquidation
578 of an insolvent insurer shall belong to and be payable at the direction
579 of the association, and the association shall be liable for unearned
580 premiums due to policy or contract owners arising after the entry of
581 the order.

582 (e) The protection provided by sections 38a-858 to 38a-875,
583 inclusive, shall not apply where any guaranty protection is provided to
584 residents of this state by the laws of the domiciliary state or
585 jurisdiction of the impaired or insolvent insurer other than this state.

586 (f) Repealed by P.A. 87-290, S. 7, 8.

587 (g) In carrying out its duties under subsection (b) of this section, the
588 association may:

589 (1) Subject to approval by a court in this state, impose permanent
590 policy or contract liens in connection with a guarantee, assumption or
591 reinsurance agreement, if the association finds that the amounts which
592 can be assessed under sections 38a-858 to 38a-875, inclusive, are less
593 than the amounts needed to assure full and prompt performance of the
594 association's duties under sections 38a-858 to 38a-875, inclusive, or that
595 the economic or financial conditions as they affect member insurers are
596 sufficiently adverse to render the imposition of such permanent policy
597 or contract liens to be in the public interest;

598 (2) Subject to approval by a court in this state, impose temporary
599 moratoriums or liens on payments of cash values and policy loans, or
600 any other right to withdraw funds held in conjunction with policies or
601 contracts, in addition to any contractual provisions for deferral of cash
602 or policy loan value. In addition, in the event of a temporary
603 moratorium or moratorium charge imposed by the receivership court

604 on payment of cash values or policy loans, or on any other right to
605 withdraw funds held in conjunction with policies or contracts, out of
606 the assets of the impaired or insolvent insurer, the association may
607 defer the payment of cash values, policy loans or other rights by the
608 association for the period of the moratorium or moratorium charge
609 imposed by the receivership court, except for claims covered by the
610 association to be paid in accordance with a hardship procedure
611 established by the liquidator or rehabilitator and approved by the
612 receivership court.

613 (h) If the association fails to act within a reasonable period of time
614 with respect to any insolvent insurer, as provided in subsection (b) of
615 this section, the commissioner shall have the powers and duties of the
616 association under sections 38a-858 to 38a-875, inclusive, with respect to
617 the insolvent insurer.

618 (i) The association may render assistance and advice to the
619 commissioner, upon the commissioner's request, concerning
620 rehabilitation, payment of claims, continuation of coverage, or the
621 performance of other contractual obligations of an impaired or
622 insolvent insurer.

623 (j) The association shall have standing to appear or intervene before
624 a court or agency in this state with jurisdiction over an impaired or
625 insolvent insurer concerning which the association is or may become
626 obligated under sections 38a-858 to 38a-875, inclusive, or with
627 jurisdiction over any person or property against which the association
628 may have rights through subrogation or otherwise. Such standing shall
629 extend to all matters germane to the powers and duties of the
630 association, including, but not limited to, proposals for reinsuring,
631 reissuing, modifying or guaranteeing the policies or contracts and
632 contractual obligations. The association shall also have the right to
633 appear or intervene before a court or agency in another state with
634 jurisdiction over an impaired or insolvent insurer for which the
635 association is or may become obligated or with jurisdiction over any
636 person or property against whom the association may have rights

637 through subrogation or otherwise.

638 (k) (1) A person receiving benefits under sections 38a-858 to 38a-875,
639 inclusive, whether the benefits are payments of or on account of
640 contractual obligations, continuation of coverage or provision of
641 substitute or alternative policies, contracts or coverages, shall be
642 deemed to have assigned (A) the rights under the covered policy or
643 contract to the association to the extent of the benefits received under
644 sections 38a-858 to 38a-875, inclusive, and (B) any causes of action
645 against any person for losses arising under, resulting from or
646 otherwise relating to, the covered policy or contract to the association
647 to the extent of the benefits received because of sections 38a-858 to 38a-
648 875, inclusive. The association may require an assignment to it of such
649 rights or cause of action by any enrollee, payee, policy or contract
650 owner, beneficiary, insured or annuitant as a condition precedent to
651 the receipt of any right or benefits under sections 38a-858 to 38a-875,
652 inclusive, upon the person.

653 (2) The subrogation rights of the association under this subsection
654 shall have the same priority against the assets of the impaired or
655 insolvent insurer as that possessed by the person entitled to receive
656 benefits under sections 38a-858 to 38a-875, inclusive.

657 (3) In addition to subdivisions (1) and (2) of this subsection, the
658 association shall have, originally or by succession, all common law
659 rights of subrogation and any other equitable or legal remedy that
660 would have been available to the impaired or insolvent insurer or
661 owner, beneficiary, enrollee or payee of a policy or contract with
662 respect to the policy or contracts, against a person responsible for the
663 losses arising from the personal injury relating to the annuity or
664 payment thereof, except any such person responsible solely by reason
665 of serving as an assignee with respect to a qualified assignment under
666 Section 130 of the Internal Revenue Code of 1986, or any subsequent
667 corresponding internal revenue code of the United States, as from time
668 to time amended. Such rights of the association shall include, but are
669 not limited to, in the case of a structured settlement annuity, any rights

670 of the owner, beneficiary or payee of the annuity, to the extent of
671 benefits received pursuant to sections 38a-858 to 38a-875, inclusive.

672 (4) If the provisions of subdivisions (1) to (3), inclusive, of this
673 subsection are invalid or ineffective with respect to any person or
674 claim for any reason, the amount payable by the association with
675 respect to the related covered obligations shall be reduced by the
676 amount realized by any other person with respect to the person or
677 claim that is attributable to the policies or contracts, or portion thereof,
678 covered by the association.

679 (5) If the association has provided benefits with respect to a covered
680 obligation and a person recovers amounts as to which the association
681 has rights as described in subdivisions (1) to (4), inclusive, of this
682 subsection, the person shall pay to the association the portion of the
683 recovery attributable to the policies or contracts, or portion thereof,
684 covered by the association.

685 (l) In addition to the rights and powers [elsewhere] otherwise
686 provided in sections 38a-858 to 38a-875, inclusive, the association may:

687 (1) Enter into such contracts as are necessary or proper to carry out
688 the provisions and purposes of sections 38a-858 to 38a-875, inclusive;

689 (2) Sue or be sued, including, but not limited to, taking any legal
690 actions necessary or proper to recover any unpaid assessments under
691 section 38a-866, as amended by this act, and to settle claims or
692 potential claims against it;

693 (3) Borrow money to effect the purposes of sections 38a-858 to 38a-
694 875, inclusive, and any notes or other evidence of indebtedness of the
695 association not in default shall be legal investments for domestic
696 member insurers and may be carried as admitted assets;

697 (4) Employ or retain such persons as are necessary or proper to
698 handle the financial transactions of the association, and to perform
699 such other functions as become necessary or proper under sections
700 38a-858 to 38a-875, inclusive;

701 (5) Take such legal action as may be necessary or proper to avoid or
702 recover payment of improper claims;

703 (6) Exercise, for the purposes of sections 38a-858 to 38a-875,
704 inclusive, and to the extent approved by the commissioner, the powers
705 of a domestic life [or] insurer, health insurer or health care center, but
706 in no case may the association issue insurance policies or annuity
707 contracts other than those issued to perform its obligations under
708 sections 38a-858 to 38a-875, inclusive;

709 (7) Request information from a person seeking coverage from the
710 association in order to aid the association in determining its
711 obligations under sections 38a-858 to 38a-875, inclusive, with respect to
712 the person, and the person shall promptly comply with the request;
713 [and]

714 (8) Unless otherwise prohibited by law, file for an actuarially
715 justified rate or premium increase for any policy or contract for which
716 the association provides coverage under sections 38a-858 to 38a-875,
717 inclusive, provided such increase is in accordance with the terms and
718 conditions set forth in such policy or contract; and

719 ~~[(8)]~~ (9) Take other necessary or proper action to discharge its duties
720 and obligations under sections 38a-858 to 38a-875, inclusive, or to
721 exercise its powers under sections 38a-858 to 38a-875, inclusive.

722 (m) The association may join an organization of one or more other
723 state associations of similar purposes to further the purposes and
724 administer the powers and duties of the association.

725 (n) (1) At any time within one year after the date on which the
726 association becomes responsible for the obligations of a member
727 insurer, which date shall be deemed the coverage date, the association
728 may elect to succeed to the rights and obligations of the member
729 insurer that accrue on or after the coverage date and that relate to
730 policies, contracts or annuities covered, in whole or in part, by the
731 association, under any one or more indemnity reinsurance agreements

732 entered into by the member insurer as a ceding insurer and selected by
733 the association, except that the association may not exercise an election
734 with respect to a reinsurance agreement if the receiver, rehabilitator or
735 liquidator of a member insurer has previously and expressly
736 disaffirmed the reinsurance agreement. The election shall be effected
737 by a notice to the receiver, rehabilitator or liquidator and to the
738 affected reinsurers. If the association makes an election, then
739 subparagraphs (A) to (D), inclusive, of this subdivision shall apply
740 with respect to the reinsurance agreements selected by the association:

741 (A) The association shall be responsible for all unpaid premiums
742 due under the agreements for periods before, on and after the coverage
743 date, and shall be responsible for the performance of all other
744 obligations to be performed after the coverage date, in each case which
745 relate to policies, contracts or annuities covered in whole or in part by
746 the association. The association may charge policies, contracts or
747 annuities covered in part by the association, through reasonable
748 allocation methods, the costs for reinsurance in excess of the
749 obligations of the association.

750 (B) The association shall be entitled to any amounts payable by the
751 reinsurer under the agreements with respect to losses or events that
752 occur in periods after the coverage date and that relate to policies,
753 contracts or annuities covered by the association in whole or in part,
754 and upon the association's receipt of any such amount, the association
755 shall pay any beneficiary [of a] under the policy, [or] contract or
756 annuity under which the association paid only a portion of the policy,
757 [or] contract or annuity amount:

758 (i) The amount received by the association that exceeds the benefits
759 paid the beneficiary under the policy, contract or annuity; less

760 (ii) [the] The benefits paid by the association on account of the
761 policy, [or] contract or annuity less the retention of the impaired or
762 insolvent member insurer applicable to the loss or event.

763 (C) Not later than thirty days after the association's election, the

764 association and each [indemnity] reinsurer shall calculate the net
765 balance due to or from the association under each reinsurance
766 agreement as of the date of the association's election with respect to
767 policies, contracts or annuities covered, in whole or in part by the
768 association, giving full credit to all items paid by either the member
769 insurer or its receiver, rehabilitator or liquidator or the [indemnity]
770 reinsurer during the period between the coverage date and the date of
771 the association's election. Either the association or [indemnity]
772 reinsurer shall pay the net balance due the other not later than five
773 days after the completion of the calculation. If the receiver,
774 rehabilitator or liquidator has received any amounts due the
775 association pursuant to subparagraph (B) of this subdivision, the
776 receiver, rehabilitator or liquidator shall remit the same to the
777 association as promptly as practicable.

778 (D) If the association or receiver, on behalf of the association, not
779 later than sixty days after the election, pays the premiums due for
780 periods before, on and after the coverage date that relate to policies,
781 contracts or annuities covered by the association in whole or in part,
782 the reinsurer shall not be entitled to terminate the reinsurance
783 agreements insofar as the agreements relate to policies, contracts or
784 annuities covered by the association in whole or in part and shall not
785 be entitled to set off any unpaid premium due for periods prior to the
786 coverage date against amounts due the association.

787 (2) If the association does not elect to assume a reinsurance contract
788 by the date of the association election pursuant to subdivision (1) of
789 this subsection, the association shall have no rights or obligations in
790 each case for periods both before and after the date of the order of
791 liquidation with respect to the reinsurance contract.

792 [(2)] (3) If the association transfers [its obligations] policies, contracts
793 or annuities, or covered obligations with respect to such policies,
794 contracts or annuities, to another assuming insurer, and if the
795 association and the other insurer agree, the other insurer shall succeed
796 to the rights and obligations of the association under subdivision (1) of

797 this subsection, provided:

798 (A) The [indemnity] reinsurance agreements shall automatically
799 terminate for new reinsurance unless the [indemnity] reinsurer and the
800 other insurer agree to the contrary; [and]

801 (B) [the] The association's obligation to pay the beneficiary pursuant
802 to subparagraph (B) of subdivision (1) of this subsection shall no
803 longer apply on or after the date the [indemnity] reinsurance
804 agreement is transferred to the [third party] assuming insurer; [This
805 subdivision shall not apply if the association has previously expressly
806 determined in writing that it will not exercise the election referred to in
807 subdivision (1) of this subsection] and

808 (C) The transferring party shall give written notice to the affected
809 reinsurer at least thirty days prior to the effective date of the transfer.

810 [(3)] (4) The provisions of this subsection shall supersede the
811 provisions of any law of this state or of any affected reinsurance
812 agreement that provides for or requires any payment of reinsurance
813 proceeds on account of losses or events that occur in periods after the
814 [coverage date] date of the order of liquidation, to the receiver,
815 liquidator or rehabilitator of the insolvent member insurer or any other
816 person. The receiver, rehabilitator or liquidator shall remain entitled to
817 any amount payable by the reinsurer under the reinsurance agreement
818 with respect to losses or events that occur in periods prior to the
819 coverage date subject to applicable setoff provisions.

820 [(4)] (5) Except as otherwise expressly provided in this [subsection]
821 section, nothing in this [section] subsection shall alter or modify the
822 terms and conditions of the [indemnity] reinsurance agreements of the
823 insolvent member insurer. Nothing in this section shall abrogate or
824 limit any rights of any reinsurer to claim that it is entitled to rescind a
825 reinsurance agreement. Nothing in this section shall give a policy
826 owner, contract owner, enrollee, certificate holder or beneficiary an
827 independent cause of action against [an indemnity] a reinsurer that is
828 not otherwise set forth in the [indemnity] reinsurance agreement.

829 Nothing in this section shall limit or affect the association's rights as a
830 creditor of an estate against the assets of the estate. Nothing in this
831 section shall apply to reinsurance agreements covering property or
832 casualty risks.

833 (o) The board of directors of the association shall have discretion
834 and may exercise reasonable business judgment to determine the
835 means by which the association is to provide the benefits [of] under
836 sections 38a-858 to 38a-875, inclusive, in an economical and efficient
837 manner.

838 (p) Where the association has arranged or offered to provide the
839 benefits [of] under sections 38a-858 to 38a-875, inclusive, to a covered
840 person under a plan or arrangement that fulfills the association's
841 obligations under sections 38a-858 to 38a-875, inclusive, the person
842 shall not be entitled to benefits from the association in addition to or
843 other than those provided under the plan or arrangement.

844 (q) Venue in a suit against the association arising under sections
845 38a-858 to 38a-875, inclusive, shall be in the superior court for the
846 judicial district of Hartford. The association shall not be required to
847 give an appeal bond in an appeal that relates to a cause of action
848 arising under sections 38a-858 to 38a-875, inclusive.

849 (r) In carrying out its duties in connection with guaranteeing,
850 assuming, reissuing or reinsuring policies or contracts under
851 subsections (a) or (b) of this section, the association may [, subject to
852 approval of the receivership court,] issue substitute coverage for a
853 policy or contract that provides an interest rate, crediting rate or
854 similar factor determined by use of an index or other external reference
855 stated in the policy or contract employed in calculating returns or
856 changes in value by issuing an alternative policy or contract in
857 accordance with subdivisions (1) to (3), inclusive, of this subsection:

858 (1) In lieu of the index or other external reference provided for in the
859 original policy or contract, the alternative policy or contract provides
860 for (A) a fixed interest rate, (B) payment of dividends with minimum

861 guarantees, or (C) a different method for calculating interest or
862 changes in value;

863 (2) [there] There is no requirement for evidence of insurability,
864 waiting period or other exclusion that would not have applied under
865 the replaced policy or contract; and

866 (3) [the] The alternative policy or contract is substantially similar to
867 the replaced policy or contract in all other material terms.

868 Sec. 7. Section 38a-866 of the general statutes is repealed and the
869 following is substituted in lieu thereof (*Effective July 1, 2018, and*
870 *applicable to impairments and insolvencies occurring on or after said date*):

871 (a) For the purpose of providing the funds necessary to carry out the
872 powers and duties of the association, the board of directors shall assess
873 the member insurers, separately for each account, at such times and for
874 such amounts as the board finds necessary. The association shall
875 establish a due date for each assessment which shall be at least thirty
876 days after the association has provided the member notice of the
877 assessment. Each member insurer shall pay interest on any late
878 payment at the rate of one per cent per month, or any portion thereof,
879 from the due date to the date of payment.

880 (b) There shall be two classes of assessments, as follows:

881 (1) Class A assessments shall be made for the purpose of meeting
882 administrative costs and other general expenses not related to a
883 particular impaired or insolvent insurer; and

884 (2) Class B assessments shall be authorized and called to the extent
885 necessary to carry out the powers and duties of the association under
886 section 38a-865, as amended by this act, with regard to an impaired or
887 insolvent insurer.

888 (c) (1) The amount of any Class A assessment shall be determined
889 by the board and may be authorized and called on a pro-rata or non-
890 pro-rata basis. If an assessment is made on a pro-rata basis, the board

891 may provide that the assessment be credited against future Class B
892 assessments.

893 (2) (A) The amount of any Class B assessment, except for any
894 assessment related to long-term care insurance, shall be allocated for
895 assessment purposes [among] between the accounts and among the
896 subaccounts of the life insurance and annuity account pursuant to an
897 allocation formula which may be based on the premiums or reserves of
898 the impaired or insolvent insurer or any other standard that the board,
899 in its sole discretion, deems as being fair and reasonable under the
900 circumstances.

901 (B) The amount of the Class B assessment for long-term care
902 insurance written by the impaired or insolvent insurer shall be
903 allocated according to a methodology included in the plan of operation
904 and approved by the commissioner. The methodology shall provide
905 for fifty per cent of the assessment to be allocated to accident and
906 health member insurers and fifty per cent to be allocated to life and
907 annuity member insurers.

908 [(2)] (3) Class B assessments against member insurers for each
909 account and subaccount shall be in the proportion that the premiums
910 received on business in this state by each assessed member insurer on
911 policies or contracts covered by each account for the three most recent
912 calendar years for which information is available preceding the year in
913 which the member insurer became insolvent or, in the case of an
914 assessment with respect to an impaired insurer, the three most recent
915 calendar years for which information is available preceding the year in
916 which the member insurer became impaired bear to such premiums
917 received on business in this state for those calendar years by all
918 assessed member insurers.

919 [(3)] (4) Assessments for funds to meet the requirements of the
920 association with respect to an impaired or insolvent insurer shall not
921 be authorized or called until necessary to implement the purposes of
922 sections 38a-858 to 38a-875, inclusive. Classification of assessments
923 under subsection (b) of this section and computation of assessments

924 under this subsection shall be made with a reasonable degree of
925 accuracy, recognizing that exact determinations may not always be
926 possible. The association shall notify each member insurer of its
927 anticipated pro-rata share of an authorized assessment that is not yet
928 called not later than one hundred eighty days after the association
929 authorizes the assessment.

930 (d) The association may abate or defer, in whole or in part, the
931 assessment of a member insurer if, in the opinion of the board,
932 payment of the assessment would endanger the ability of the member
933 insurer to fulfill its contractual obligations. In the event an assessment
934 against a member insurer is abated, or deferred in whole or in part, the
935 amount by which such assessment is abated or deferred may be
936 assessed against the other member insurers in a manner consistent
937 with the basis for assessments set forth in this section. Once the
938 conditions that caused a deferral have been removed or rectified, the
939 member insurer shall pay all assessments that were deferred pursuant
940 to a repayment plan approved by the association.

941 (e) (1) (A) Subject to the provisions of subparagraph (B) of this
942 subdivision, the total of all assessments authorized by the association
943 with respect to a member insurer for each subaccount of the life
944 insurance and annuity account and for the health [insurance] account
945 shall not in any one calendar year exceed two per cent of such insurer's
946 average annual premiums received in this state on the policies and
947 contracts covered by the subaccount or account during the three
948 calendar years preceding the year in which the member insurer
949 became an impaired or insolvent insurer.

950 (B) If two or more assessments are authorized in one calendar year
951 with respect to member insurers that become impaired or insolvent in
952 different calendar years, the average annual premiums for purposes of
953 the aggregate assessment percentage shall be equal and limited to the
954 higher of the three-year average annual premium for the applicable
955 subaccount or account as calculated pursuant to this section.

956 (C) If the maximum assessment, together with the other assets of the

957 association in any account, does not provide in any one year in either
958 account an amount sufficient to carry out the responsibilities of the
959 association, the necessary additional funds shall be assessed as soon
960 thereafter as permitted by sections 38a-858 to 38a-875, inclusive.

961 (2) The board may provide in the plan of operation a method of
962 allocating funds among claims, whether relating to one or more
963 impaired insurers, when the maximum assessment will be insufficient
964 to cover anticipated claims.

965 (3) If the maximum assessment for any subaccount of the life
966 insurance and annuity account in any one year does not provide an
967 amount sufficient to carry out the responsibilities of the association,
968 then pursuant to subdivision [(2)] (3) of subsection (c) of this section,
969 the board shall access the other subaccounts of the life insurance and
970 annuity account for the necessary additional amount, subject to the
971 maximum stated in subdivision (1) of this subsection.

972 (f) The board may, by an equitable method as established in the plan
973 of operation, refund to member insurers, in proportion to the
974 contribution of each member insurer to that account, the amount by
975 which the assets of the account exceed the amount the board finds is
976 necessary to carry out during the coming year the obligations of the
977 association with regard to that account, including assets accruing from
978 assignment, subrogation, net realized gains and income from
979 investments. A reasonable amount may be retained in any account to
980 provide funds for the continuing expenses of the association and for
981 future losses if refunds are impractical.

982 (g) It shall be proper for any member insurer, in determining its
983 premium rates and policy owner dividends as to any kind of insurance
984 or health care center business within the scope of sections 38a-858 to
985 38a-875, inclusive, to consider the amount reasonably necessary to
986 meet its assessment obligations under said sections.

987 (h) (1) Each member insurer paying an assessment under sections
988 38a-858 to 38a-875, inclusive, may offset one hundred per cent of the

989 amount of such assessment against its premium tax liability to this
990 state under chapter 207. Such offset shall be taken over a period of the
991 five successive tax years following the year of payment of the
992 assessment, at the rate of twenty per cent per year of the assessment
993 paid to the association. Each member insurer to which has been
994 refunded by the association, pursuant to subsection (f) of this section,
995 all or a portion of an assessment previously paid to the association by
996 the member insurer shall be required to pay to the Department of
997 Revenue Services an amount equal to the total amount that has been
998 claimed as an offset against the premiums tax liability on the
999 premiums tax return or returns, as the case may be, filed by such
1000 insurer and that is attributable to such refunded assessment, provided
1001 the amount required to be paid to said department shall not exceed the
1002 amount of the refunded assessment. If the amount of the refunded
1003 assessment exceeds the total amount that has been claimed as an offset
1004 against the premiums tax liability on the premiums tax return or
1005 returns filed by such member insurer and that is attributable to such
1006 refunded assessment, such excess may not be claimed as an offset
1007 against the premiums tax liability on a premiums tax return or returns
1008 filed by such insurer or, if the offset has been transferred to another
1009 person pursuant to subdivision (2) of this subsection, by such other
1010 person. For purposes of this subdivision, if the offset has been
1011 transferred to another person pursuant to subdivision (2) of this
1012 subsection, the total amount that has been claimed as an offset against
1013 the premiums tax liability on the premiums tax return or returns filed
1014 by such insurer includes the total amount that has been claimed as an
1015 offset against the premiums tax liability on the premiums tax return or
1016 returns filed by such other person. The association shall promptly
1017 notify the Commissioner of Revenue Services of the name and address
1018 of the member insurers to which such refunds have been made, the
1019 amount of such refunds, and the date on which such refunds were
1020 mailed to each such insurer. If the amount that [an] a member insurer
1021 is required to pay to the Department of Revenue Services has not been
1022 so paid on or before the forty-fifth day after the date of mailing of such
1023 refunds, the insurer shall be liable for interest on such amount at the

1024 rate of one per cent per month, or fraction thereof, from such forty-fifth
1025 day to the date of payment.

1026 (2) [An] A member insurer, in this subdivision called "the
1027 transferor", may transfer any offset provided under subdivision (1) of
1028 this subsection to an affiliate, as defined in section 38a-1, of the
1029 transferor. Any such transfer of the offset by the transferor, and any
1030 subsequent transfer or transfers of the same offset, shall not affect the
1031 obligation of the transferor to pay to the Department of Revenue
1032 Services any sums which are acquired by refund from the association
1033 pursuant to subsection (f) of this section and which are required to be
1034 paid to the Department of Revenue Services pursuant to subdivision
1035 (1) of this subsection. Such offset may be taken by any transferee only
1036 against the transferee's premium tax liability to this state under
1037 chapter 207. The Commissioner of Revenue Services shall not allow
1038 such offset to a transferee against its premium tax liability unless the
1039 transferor, the affiliate to which the offset was originally transferred,
1040 each subsequent transferor and each subsequent transferee have filed
1041 such information as may be required on forms provided by said
1042 commissioner with respect to any such transfer or transfers on or
1043 before the due date of the premium tax return on which such offset
1044 would have been taken by the transferor, if no transfer had been made
1045 by the transferor.

1046 (i) (1) A member insurer that wishes to protest all or part of an
1047 assessment shall pay when due the full amount of the assessment as
1048 set forth in the notice provided by the association. The payment shall
1049 be available to meet association obligations during the pendency of the
1050 protest or any subsequent appeal. Payment shall be accompanied by a
1051 written statement that (A) the payment is made under protest, and (B)
1052 includes a brief statement of the grounds for the protest.

1053 (2) Not later than sixty days following the payment of an assessment
1054 under protest by a member insurer, the association shall notify the
1055 member insurer in writing of its determination with respect to the
1056 protest unless the association notifies the member insurer that

1057 additional time is required to resolve the issues raised by the protest.

1058 (3) Not later than thirty days after a final decision has been made,
1059 the association shall notify the protesting member insurer in writing of
1060 the final decision.

1061 (4) Not later than sixty days after receipt of notice of the final
1062 decision, the protesting member insurer may appeal the final action to
1063 the commissioner.

1064 (5) In the alternative to rendering a final decision with respect to a
1065 protest based on a question regarding the assessment base, the
1066 association may refer protests to the commissioner for a final decision,
1067 with a recommendation from the association.

1068 (6) If the protest or appeal on the assessment is upheld, the amount
1069 paid in error or excess shall be returned to the member [company]
1070 insurer. Interest on a refund due a protesting member insurer whose
1071 protest or appeal was upheld shall be paid at the rate actually earned
1072 by the association.

1073 (j) The association may request information from member insurers
1074 in order to aid in the exercise of its power under this section and
1075 member insurers shall promptly comply with such request.

1076 Sec. 8. Section 38a-871 of the general statutes is repealed and the
1077 following is substituted in lieu thereof (*Effective July 1, 2018, and*
1078 *applicable to impairments and insolvencies occurring on or after said date*):

1079 (a) Nothing in sections 38a-858 to 38a-875, inclusive, shall be
1080 construed to reduce the liability for unpaid assessments of the insureds
1081 of an impaired insurer operating under a plan with assessment
1082 liability.

1083 (b) Records shall be kept of all negotiations and meetings in which
1084 the association or its representatives are involved to discuss the
1085 activities of the association in carrying out its powers and duties under
1086 section 38a-865, as amended by this act. Records of such negotiations

1087 or meetings shall be made public only upon the termination of a
1088 liquidation, rehabilitation, or conservation proceeding involving the
1089 impaired insurer, upon the termination of the impairment of the
1090 insurer, or upon the order of a court of competent jurisdiction. Nothing
1091 in this subsection shall limit the duty of the association to render a
1092 report of its activities under section 38a-872.

1093 (c) For the purpose of carrying out its obligations under sections
1094 38a-858 to 38a-875, inclusive, the association shall be deemed to be a
1095 creditor of the impaired insurer to the extent of assets attributable to
1096 covered policies reduced by any amounts to which the association is
1097 entitled as subrogee pursuant to subdivision (i) of section 38a-865, as
1098 amended by this act. All assets of the impaired insurer attributable to
1099 covered policies shall be used to continue all covered policies and pay
1100 all contractual obligations of the impaired insurer as required by
1101 sections 38a-858 to 38a-875, inclusive. Assets attributable to covered
1102 policies or contracts, as used in this subsection, is that proportion of
1103 the assets which the reserves that should have been established for
1104 such policies or contracts bear to the reserve that should have been
1105 established for all policies or contracts of insurance or health care
1106 center subscriber contracts and certificates written by the impaired or
1107 insolvent insurer.

1108 (d) (1) Prior to the termination of any liquidation, rehabilitation or
1109 conservation proceeding, the court may take into consideration the
1110 contributions of the respective parties, including the association, the
1111 shareholders, contract owners, certificate holders, enrollees and
1112 [policyowners] policy owners of the [impaired] insolvent insurer, and
1113 any other party with a bona fide interest, in making an equitable
1114 distribution of the ownership rights of such [impaired] insolvent
1115 insurer. In such a determination, consideration shall be given to the
1116 welfare of the [policyholders] policy holders, contract owners,
1117 certificate holders and enrollees of the continuing or successor member
1118 insurer.

1119 (2) No distribution to stockholders, if any, of an impaired or

1120 insolvent insurer shall be made until and unless the total amount of
1121 [assessments levied by the association with respect to such insurer has
1122 been fully recovered by the commission] valid claims of the association
1123 with interest thereon for funds expended in carrying out its powers
1124 under section 38a-865, as amended by this act, with respect to the
1125 member insurer have been fully recovered by the association.

1126 (e) It shall be a prohibited unfair trade practice and a violation of
1127 section 38a-815 for any person to make use in any manner of the
1128 protection afforded by sections 38a-858 to 38a-875, inclusive, in the
1129 solicitation, negotiation, procurement or effectuation of insurance
1130 provided, this subsection shall not apply to the distribution of any
1131 publication approved by the commissioner and describing the general
1132 purposes and current limitations of sections 38a-858 to 38a-874,
1133 inclusive. Violations of this section shall be subject to the provisions of
1134 section 38a-817.

1135 (f) (1) If an order for liquidation or rehabilitation of [an] a member
1136 insurer domiciled in this state has been entered, the receiver appointed
1137 under such order shall have a right to recover on behalf of the member
1138 insurer, from any affiliate that controlled it, the amount of
1139 distributions, other than stock dividends paid by the member insurer
1140 on its capital stock, made at any time during the five years preceding
1141 the petition for liquidation or rehabilitation subject to the limitations of
1142 subdivisions (2) to (4), inclusive, of this subsection.

1143 (2) No such dividend shall be recoverable if the member insurer
1144 shows that [when paid] the distribution was lawful and reasonable
1145 when paid, and that the member insurer did not know and could not
1146 reasonably have known that the distribution might adversely affect the
1147 ability of the member insurer to fulfill its contractual obligations.

1148 (3) Any person who was an affiliate that controlled the member
1149 insurer at the time the distributions were paid shall be liable up to the
1150 amount of distributions [he] such person received. Any person who
1151 was an affiliate that controlled the member insurer at the time the
1152 distributions were declared shall be liable up to the amount of

1153 distributions [he] which such person would have received if [they]
 1154 such person had been paid immediately. If two persons are liable with
 1155 respect to the same distributions, they shall be jointly and severally
 1156 liable.

1157 (4) The maximum amount recoverable under this subsection shall be
 1158 the amount needed in excess of all other available assets of the
 1159 [impaired] insolvent insurer to pay the contractual obligations of the
 1160 [impaired] insolvent insurer.

1161 (5) If any person liable under subdivision (3) of this subsection is
 1162 insolvent, all its affiliates that controlled it at the time the dividend was
 1163 paid shall be jointly and severally liable for any resulting deficiency in
 1164 the amount recovered from the insolvent affiliate.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2018</i>	38a-859
Sec. 2	<i>July 1, 2018, and applicable to impairments and insolvencies occurring on or after said date</i>	38a-860
Sec. 3	<i>July 1, 2018</i>	38a-862
Sec. 4	<i>July 1, 2018</i>	38a-863(a)
Sec. 5	<i>July 1, 2018</i>	38a-864(a)
Sec. 6	<i>July 1, 2018, and applicable to impairments and insolvencies occurring on or after said date</i>	38a-865
Sec. 7	<i>July 1, 2018, and applicable to impairments and insolvencies occurring on or after said date</i>	38a-866
Sec. 8	<i>July 1, 2018, and applicable to impairments and insolvencies occurring on or after said date</i>	38a-871

Statement of Legislative Commissioners:

In Section 6(b)(2)(I), after "policy" "or contract" was inserted and after "the insured" "the enrollee" was inserted for accuracy.

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 19 \$	FY 20 \$
Resources of the General Fund	GF - Potential Revenue Loss	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in a potential revenue loss to the General Fund to the extent that the expansion of membership in the Connecticut Life and Health Insurance Guaranty Association (CLHIGA) results in increased tax credit utilization.

Members of CLHIGA are permitted to fully offset assessments paid through Insurance Premium Tax credits. It is assumed that the expansion in CLHIGA membership by including health care centers will increase the risk of a default among the membership in any one year. More frequent assessments equate to a revenue loss as more Insurance Premium Tax credits are claimed.

There is no fiscal impact to the Insurance Department because the requirement in the bill for the Insurance Commissioner to approve certain policies and rates falls within current department activities.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future.

Sources: Connecticut Insurance Department

OLR Bill Analysis**sHB 5205*****AN ACT CONCERNING THE CONNECTICUT LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.*****SUMMARY**

This bill makes several substantive changes to the Connecticut Life and Health Insurance Guaranty Association (CLHIGA), which pays the valid claims of policyholders and certain other claimants when a member insurer defaults, generally up to a statutory maximum of \$500,000 per individual and \$5 million per plan sponsor for certain unallocated insurance contracts. These claims are paid through assessments on member insurers. The bill:

1. requires health care centers (i.e., HMOs) to participate in the association, which (a) broadens the scope of members who are assessed for an impairment or insolvency and (b) requires CLHIGA to cover HMO members and enrollees for impairment or insolvency;
2. equalizes the assessments for long-term care (LTC) insurer insolvencies between (a) accident and health insurers and (b) life and annuity insurers;
3. excludes from coverage Medicaid benefits and certain financial contracts and structured settlements;
4. increases the potential size of the association's board of directors;
5. includes government entities as people who can be protected under CLHIGA; and
6. makes several other related changes.

The bill also makes numerous minor, technical, and conforming changes.

EFFECTIVE DATE: July 1, 2018, with certain coverage and assessment provisions applicable to impairments and insolvencies occurring on or after that date.

§ 2 — NEW COVERAGE EXCLUSIONS

The bill excludes from CLHIGA coverage:

1. individuals who acquired rights to receive payment through structured settlement factoring transactions (e.g., an exchange of annuity rights for a lump sum payment), regardless of the transaction's effective date;
2. structured settlement annuity benefits transferred in a factoring transaction, regardless of the transaction's effective date;
3. any portion of policies or contracts for which federal or state law preempts guaranty association assessments; and
4. Medicaid benefits

§§ 3 & 4 — HEALTH CARE CENTERS

By law, CLHIGA generally covers policies and contracts that are issued by its members and meet certain other conditions. The bill (1) requires HMOs to be member insurers as a condition of conducting health care center business in the state and (2) expands CLHIGA coverage to HMO members and enrollees. Under the bill, health insurance covered under CLHIGA includes a health care center subscriber contract or certificate. It also makes conforming changes throughout the statutes.

§ 5 — BOARD OF DIRECTORS

The bill increases the (1) minimum number of board members from 5 to 7 and (2) maximum number of board members from 9 to 11. In practice, there are 9 member insurers on the board, excluding the insurance commissioner who serves as non-voting ex-officio member.

§ 6 — ALTERNATE POLICIES FOR INSOLVENT INSURER GROUP POLICIES

By law, an insolvent insurer's policies terminate no more than 45 days for group policies or one year for nongroup policies after the insurer is ordered liquidated. Under current law, CLHIGA must then (1) guarantee, assume, or reinsure an insolvent insurer's policies and contracts or otherwise assure payment of its obligations or (2) issue an alternative policy or otherwise provide the benefits and coverages that would have been payable under the policies or contracts while maintaining the same premium. The bill allows CLHIGA to fulfill this requirement by reissuing the insolvent insurer's policies. It also appears to eliminate the requirement that alternative coverage be offered at the same premium.

For certain group policies and contracts issued by the insolvent insurer that gave an insured the right to convert to individual coverage or continue a policy or annuity until a specific time during which the insurer was prohibited from making unilateral changes, the bill allows CLHIGA to offer alternative coverage at actuarially justified rates (presumably instead of the premium rate previously charged to the insured by the insolvent insurer).

Under the bill, alternative policies adopted by the association need the insurance commissioner's approval. Under current law, they require approval from the receivership court and the insurance commissioner of the insurer's domiciled state.

The bill makes a similar change to reissued policies. Under the bill, if CLHIGA reissues terminated coverage at a new premium rate, the new rate must be (1) actuarially justified in relation to the amount of insurance or coverage provided and (2) approved by the insurance commissioner, instead of the receivership court and the insurance commissioner of the insured's domiciled state.

The bill also allows CLHIGA to reissue an impaired insurer's policies.

The bill also allows the association to, unless otherwise prohibited by law and for any coverage it provides, file for an actuarially justified rate increase as long as the increase is in accordance with the policy's or contract's terms and conditions.

§ 6 — RIGHTS UNDER REINSURANCE

By law, CLHIGA may succeed to any rights and obligations of an insolvent or impaired member insurer that accrue on or after the date CLHIGA becomes responsible for its obligations. Under the bill, the association has no rights or obligations under a reinsurance contract if it does not elect to assume such contract's obligations within a year. If the association transfers its obligations to an assuming reinsurer, it must notify the affected reinsurer at least 30 days before the transfer.

By law, CLHIGA's obligations to an impaired or insolvent insurer cease after a reinsurance agreement is ceded to an assuming insurer. The bill eliminates a provision that exempts CLHIGA from existing reinsurance requirements if it expressly determines, in writing, that it will not transfer its obligations to an assuming insurer. Under current law, these provisions supersede any state law or reinsurance agreement that requires a payment on reinsurance proceeds due to losses or events occurring after CLHIGA assumes an insolvent insurer's obligation. The bill instead supersedes any such law or agreement requiring payment after a liquidation order.

The bill also specifies that provisions relating to CLHIGA powers and obligations do not (1) limit or affect the association's rights as a creditor of an estate or (2) apply to property and casualty risks.

§ 7 — EQUALIZED ASSESSMENTS FOR LONG TERM CARE INSURANCE

By law, CLHIGA may assess its members for (1) administrative costs and general expenses ("Class A" assessments) and (2) costs necessary to carry out the association's duties to guarantee an impaired or insolvent insurer's obligations ("Class B" assessments). By law, Class B assessments are allocated among the association's two accounts: the health insurance account (which the bill renames the

“health account”) and the life insurance account. Assessments on individual insurers are generally proportional to the premiums they receive in the relevant lines of insurance.

The bill requires Class B assessments related to LTC insurance to be allocated (1) separately from other Class B assessments and (2) evenly between (a) accident and health member insurers and (b) life and annuity member insurers. The bill requires the allocation to be according to a methodology included in the plan of operation and approved by the insurance commissioner.

OTHER CHANGES

Interest on Returned Assessments (§ 7)

By law, member insurers may protest an assessment, and if successful, receive a refund on any erroneously paid amounts. The bill requires CLHIGA to pay interest on returned assessments at the rate it was earned to any insurer that successfully appealed, instead of any member that protests, as currently required.

Recovery of Assessments (§ 8)

Current law prohibits a stockholder distribution of an impaired insurer until and unless CLHIGA recoups the total amount of any assessment. The bill instead prohibits such distributions until all of CLHIGA’s valid claims have been recovered with interest. The bill also extends this prohibition to insolvent, not just impaired, insurers.

The bill also applies, to insolvent rather than impaired insurers, provisions on (1) distributing ownership rights during liquidation, rehabilitation, or conservation proceedings and (2) the maximum amount of distributions recoverable by an appointed receiver. By law, an impaired insurer is an insurer placed under a rehabilitation or conservation order, and an insolvent insurer is an insurer placed under a liquidation order.

Interest Rate Limitations and LTC Riders (§ 2)

The law limits CLHIGA coverage in certain circumstances,

including when a portion of a policy or contract included an interest rate that exceeds statutory limits. The bill excludes any health insurance or LTC insurance policies from this coverage limitation.

The bill also requires CLHIGA, when determining coverage, to consider an LTC rider on a life insurance policy or annuity contract as the same type of benefits provided by the underlying policy (e.g., a LTC rider on a life insurance policy would be considered, for coverage purposes, a life insurance benefit).

Health Care Providers (§ 2)

The bill also specifies that health care providers rendering services under a health insurance policy or contract covered by CLHIGA are eligible for coverage (e.g., reimbursement for services rendered).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 21 Nay 0 (03/15/2018)